Surgical and Nonpsychiatric Medical Treatment of Patients With Body Dysmorphic Disorder

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It appears that many individuals with body dysmorphic disorder (BDD) receive nonpsychiatric medical treatment and surgery; however, this topic has had little systematic investigation. This study assessed the nonpsychiatric treatment sought and received by 289 individuals (250 adults and 39 children/adolescents) with DSM-IV BDD. Such treatment was sought by 76.4% and received by 66.0% of adults. Dermatologic treatment was most often received (by 45.2% of adults), followed by surgery (by 23.2%). These treatments rarely improved BDD symptoms. Results were similar in children/adolescents. These findings indicate that a majority of patients with BDD receive nonpsychiatric treatment but tend to respond poorly. (Psychosomatics 2001; 42:504–510)

Body dysmorphic disorder (BDD), also known as dysmorphophobia, is a relatively common disorder[1,2] that consists of a distressing and impairing preoccupation with a nonexistent or slight defect in appearance. It appears that these patients often seek surgical, dermatologic, and other nonpsychiatric medical treatment for their perceived appearance flaws and that the outcome is often poor.[3–6] Studies have reported rates of BDD of 7%[7] and 15%[8] in patients seeking cosmetic surgery and a rate of 12% in patients seeking dermatologic treatment.[9] However, the types of treatment sought by patients with BDD and the outcome of such treatment has received very little systematic investigation.

The surgery literature discusses patients with characteristics that have some overlap with BDD, such as "insatiable" surgery patients,[10] patients with "minimal deformity",[11] "psychologically disturbed" patients,[12] and "polysurgical addicts."[13] It is unclear, however, which and how many of these patients have DSM-IV-defined BDD. There are some suggestions that certain patients with minimal deformity or psychological disturbance are good surgical candidates.[11,12,14] However, many authors caution against performing surgery on these patients, especially those identified as having BDD, because of poor outcomes that include dissatisfaction with the procedure[10,15] or violence toward the surgeon.[16–18] In particular, cosmetic surgery in men has been cited as sometimes generating aggression toward the surgeon, even triggering murder.[16,18]

The dermatology literature notes that individuals with "dermatological hypochondriasis"[19] or "dermatological non-disease",[20] who resemble patients with BDD, often seek dermatologic treatment, including laser therapy or dermabrasion.[20] A number of authors state that these patients are often difficult to treat and frequently have a poor treatment outcome.[20,21–23] Case reports of patients with BDD seeking dental treatment or orthognathic surgery have been published, with mixed treatment outcomes reported.[24,25]

In reports from psychiatric settings, a relatively high percentage of BDD patients have sought and received nonpsychiatric treatment for their perceived appearance flaws,[4–6,26] which appears to rarely improve BDD symptoms.[6,26] However, the literature has been limited by small numbers of subjects, a lack of detailed description of treat-

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ment outcome and types of treatment sought and received, and a lack of data on why requested treatment is not received.

In this study, we assessed the frequency, types, and outcomes of nonpsychiatric medical, surgical, and dental treatment sought and received by 289 patients with BDD seen in a psychiatric setting. This is, to our knowledge, the largest series of patients with DSM-IV BDD. Because much of the surgical and dermatologic literature warns against treating patients with minimal or nonexistent defects, we determined how often, and why, BDD patients did not receive such treatment. And because some authors warn in particular against performing cosmetic surgery in men,[16,18] we determined whether men were more often refused surgery than women and whether surgical outcome was worse for men. In addition, we hypothesized that patients with more severe BDD symptoms and those with poorer insight would be more likely to seek and receive nonpsychiatric treatment.

METHOD

Subjects

Study subjects were 289 consecutive individuals with DSM-IV BDD (250 adults and 39 children/adolescents) who were evaluated and/or treated in a BDD research program. Patients with a delusional belief about their appearance flaws (delusional disorder, somatic type) were included because available data suggest that the delusional and nondelusional forms of BDD are variants of the same disorder,[27] and they may be double-coded in DSM-IV. Informed consent/assent was obtained after the study was fully explained; for children, consent was also obtained from the child's legal guardian.

A majority of the adults (62.0%; $n = 155$) participated in a BDD phenomenology study, which has been described elsewhere,[5] and 38.0% ($n = 95$) participated in BDD pharmacotherapy studies.[28] The adults had a mean age of 33.0 ± 10.3 years (range = 18–80); 52.4% ($n = 131$) were female. Regarding marital status 66.4% ($n = 166$) had never been married, 20.8% ($n = 52$) were married, and 12.8% ($n = 32$) were divorced. The mean age at BDD onset was 16.9 ± 7.4 (range = 4–43) years, with a mean duration of illness of 15.5 ± 11.6 (range = <1–69) years. The 39 children and adolescents participated in a descriptive study of BDD's clinical features in this age group.[29] They had a mean age of 14.7 ± 2.5 (range = 6–17) years, and 87.2% ($n = 34$) were female. The mean age of BDD onset in this group was 11.7 ± 2.7 (range = 5–17) years. Among adults and adolescents combined, the most common areas of concern were the skin (e.g., acne or scarring; 69.0%; $n = 169$), hair (55.7%; $n = 137$), and nose (35.7%; $n = 87$), although any body area could be the focus of concern. Over the course of their illness, subjects were concerned with 3.8 ± 2.4 (range = 1–13) body areas. The most common lifetime comorbid disorders were major depression (73.7%; $n = 182$), social phobia (36.8%; $n = 91$), and substance use disorders (31.6%; $n = 79$).

Assessments

By use of a clinician-administered semistructured instrument[5] (Phillips KA, unpublished data), information was retrospectively obtained about the frequency of nonpsychiatric treatment sought and received in the following categories: dermatologic, surgical, other medical (e.g., ophthalmologic), dental, and paraprofessional (e.g., electrolysis). Whereas one surgical procedure was counted as one surgery, an entire course of treatment with a dentist (e.g., orthodontia) or a paraprofessional (e.g., a course of electrolysis) was counted as one treatment. An entire course of treatment received from a particular dermatologist or other nonsurgeon physician (e.g., internist, ophthalmologist) was also counted as one treatment because patients were often unable to recall specific, individual types of treatment (such as different types of oral or topical antibiotics) received from these physicians. Thus, frequencies of dermatologic and "other medical" treatment received represent the number of different physicians seen rather than the number of different types of treatment received. Information was also obtained on why treatment sought from a professional was not actually received.

Response to these treatments was assessed with the Clinical Global Impressions Scale (CGI).[30] Ratings of "much" or "very much" improved on the CGI were considered to indicate improvement; ratings of "much" or "very much" worse were considered worsening; and ratings of "minimally improved," "unchanged," or "minimally worse" constituted no change. (Early in the study, "moderate" or "marked" improvement was used instead of "much" or "very much" improved and was considered indicative of improvement.) From the beginning of the study, treatment response was assessed for overall response of BDD symptoms; later in the study, treatment outcome was also obtained specifically for the treated body part (i.e., whether the subject worried less about and was less distressed by the treated body part per se). Several other vari-